MINOR PATIENT REGISTRATION
David A Ewing-Chow M.D. PLLC
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http://daewingchowmd.portalforpatients.com

Patient Name:				**Date:**
Date of Birth:	**Age:**	**Sex:**	**Gender:**	**Orientation:**
Race: __Caucasian __African American __Asian __Hispanic __Other			**Account #:**	

Address:		**P.O. Box:**
City:	**State:**	**Zip:**
Parent Cell:	**Home:**	**Parent Work:**
Parent Email:	**Patient Portal Sign Up: YES OR NO**	
Appointment Reminder (select ONE preference): Phone #: VOICE EMAIL TEXT		

Primary Care Doctor:	**Referring Doctor:**
Care Team Doctor & Address:	
Care Team Doctor & Address:	
Pharmacy Name & Address:	
Consent to send glasses RX to Optical Shop YES or NO	**Name of Facility:**

GUARANTOR – Who should receive statements for this minor patient?

Name:	**SSN:**	**DOB:**
Address:		
Cell:	**Home:**	**Work:**

PRIMARY INSURANCE - WE DO NOT PAR WITH MEDICAID OR VISION INSURANCE

Company:	**Address:**	
Member ID#		**Group#**
Subscriber's Name:	**SSN**:	**DOB:**
Subscriber's Address:		

SECONDARY INSURANCE - WE DO NOT PAR WITH MEDICAID OR VISION INSURANCE

Company:	**Address:**	
Member ID#		**Group#**
Subscriber's Name:	**SSN:**	**DOB:**
Subscriber's Address:		

PARENT/GUARDIAN CONTACT

1. Parent/Guardian Name:			**DOB:**
Address:			
Relationship:	**Cell#:**	**Home#:**	**Work#:**

2. Parent/Guardian Name:			**DOB:**
Address:			
Relationship:	**Cell#:**	**Home#:**	**Work#:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any remaining balance. I also authorize **David A. Ewing-Chow, MD, PLLC** or insurance company to release information vital to process my claims.

X____ ____________

Signature of Parent/Guardian/Responsible Party Date

Edited: 01/01/2019